Recommendations for HIV Counseling and Testing For Pregnant Women

March 1998

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Recommendations for

HIV Counseling and Testing

For Pregnant Women

May 1998

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Acknowledgments

Thanks to all those persons who helped put this document together. Many hours, numerous meetings, and countless communications went into preparing the document for distribution. Lest we inadvertently leave someone out, please accept this gratitude en masse.

Kansas Department of Health and Environment
HIV Counseling and Testing for Pregnant Women

Recommendation

The Kansas Department of Health and Environment (KDHE) supports recommendations of the U.S. Public Health Service for routine Human Immunodeficiency Virus (HIV) counseling, to include risk behaviors and infection transmission, and voluntary testing for all pregnant women. This recommendation is consistent with a statement by the American Academy of Family Physicians (AAFP) and a joint statement by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP).

The U.S. Public Health Service recommendations, published July 7, 1995, were developed in response to findings of a study conducted by the National Institutes of Health showing medical benefits of zidovudine (ZDV, previously known as AZT) in reducing perinatal transmission of HIV from mother to infant (1). This study, identified as AIDS Clinical Trials Group 076, also suggested the lives of infants not protected by ZDV *in utero* may be prolonged by initiating appropriate medical care within the first months of life when the mother is HIV-positive. The Public Health Service Task Force recommendations were updated January 30, 1998 to incorporate more recent knowledge on HIV chemotherapy (2). Standard antiretroviral therapy should be discussed with and offered to HIV-infected pregnant women. To prevent perinatal transmission, ZDV chemoprophylaxis should be incorporated into the antiretroviral regime.

KDHE recognizes the importance of

- preventing HIV infection and transmission;
- pregnant women being advised of methods to prevent HIV infection and transmission;
- pregnant women knowing their HIV infection status; and
- pregnant women being informed of methods to prevent transmission of HIV to the fetus or newborn; and
- HIV-infected pregnant women, their infants, and families receiving appropriate follow-up, treatment, and care.

A variety of resources exists to provide HIV counseling and testing for pregnant women. A woman's ability to access these services relates to various factors such as history of risk, service eligibility criteria, health insurance benefits, and availability of counseling and testing or follow-up services.

Information about HIV counseling and testing programs, as well as follow-up services for persons diagnosed with HIV infection, is included in the sections that follow. Further information may be obtained by calling the AIDS Section, Bureau for Disease Prevention and Health Promotion, Kansas Department of Health and Environment at (785) 296-6173.

Background

A. HIV Infection and AIDS in Kansas' Childbearing Women and Infants

From 1990 to May 1995, KDHE conducted the Survey of Childbearing Women (SCBW). Blood samples collected from liveborn infants delivered in a Kansas hospital or maternity center and submitted to KDHE were utilized for this study. These samples were tested for four metabolic deficiency disorders: hemoglobinopathies, galactosemia, phenylketonuria, and congenital hypothyroidism. After this was completed, all personal identifiers were removed and samples were tested for HIV antibody. The data from the SCBW for 1992-1994 were analyzed to characterize the HIV prevalence in childbearing women.

KDHE tested a total of 99,367 blood samples between 1992 and 1994. Of these, 96,857 (97.5%) were negative on the Enzyme Immunoassay (EIA), 197 (0.2%) were positive, and 2,313 (2.3%) were not tested because the specimens were unsatisfactory. The EIA positive specimens were submitted for confirmation by Western Blot (WB). Of these, 19 (9.7%, 12 white, six black, and one Hispanic) were positive, 117 (59.7%) were negative, 60 (30.6%) were indeterminate, and one was corrupted and could not be analyzed. This means that 0.02% (2 per 10,000) of the newborn samples tested between 1992 and 1994 had antibodies to the AIDS virus at birth.

In addition to the SCBW, KDHE has collected information on AIDS cases reported since 1981 and has gathered case information since 1981. Of the 1,927 Kansas AIDS cases reported through December 31, 1997, nine have been reported in individuals born to HIV-infected mothers. Where data from the SCBW reveals a low incidence of HIV among childbearing women in the state, AIDS data points to the same conclusion regarding infants born to these women.

During 1992 to 1994, there were an average of 37,689 births per year in Kansas. Testing these women prenatally would have identified an average of seven HIV-infected per year. KDHE recommends the following: routine counseling for all pregnant women and voluntary testing. A provider-initiated assessment of risk will help determine which of the available counseling and testing resources is appropriate for each patient.

Details about some of these sources are given in "Options for HIV Counseling and Antibody Testing" on page three.

B. Perinatal Transmission

An infected woman can transmit HIV to her fetus or newborn during pregnancy, labor, and breast feeding. Data indicate that approximately one-half of perinatal transmitted infections from non-breast feeding women occur shortly before or during the birth process. Perinatal transmission rates have been estimated to be from 13% to 30% (3). Characteristics associated with decreased perinatal transmission have included cesarean section delivery, circulating maternal antibodies, and maternal zidovudine (ZDV) therapy.

C. Prevention and Treatment

Current strategies to eliminate perinatal transmission focus on interrupting *in utero* and *intrapartum* transmission. Results from a multicenter clinical trial indicate the administration of zidovudine to HIV-infected women during pregnancy, labor, and delivery, and to their newborns decreased the risk of perinatal transmission by two-thirds (3). The treatment regimen caused minimal adverse effects in women and children. (After 18 months, mild anemia resulted in the infants.)

Although beneficial, the treatment protocol leaves some unanswered questions, including the long-term safety of the regimen for mothers and infants and zidovudine's effectiveness in women who have different clinical characteristics from those in the trial, such as CD4+ T-lymphocyte count and previous zidovudine use. Additional data demonstrate the short-term safety of the ZDV regimen; however, long-term studies are not yet complete (2). Current U.S. Public Health Service recommendations reinforce that HIV-infected women be informed of the benefits and risks of chemotherapy.

Counseling

Although ZDV chemoprophylaxis alone has reduced the risk for perinatal transmission, when considering treatment of pregnant women with HIV infection antiretroviral monotherapy is now considered suboptimal for treatment; combination drug therapy is the current standard of care.

Pre- and post-test counseling have been included as part of HIV antibody testing services since the Food and Drug Administration first approved tests in 1985. The Kansas Department of Health and Environment regards such counseling as an essential means of educating individuals about HIV prevention and services. Counseling provides at-risk persons the opportunity to discuss their risk with a qualified professional and develop an individualized prevention plan to avoid further risk of exposure and infection.

Pre-test counseling opens the door for frank discussion, as well as assessment of actual or perceived risk. Post-test counseling offers another chance to review the individualized prevention plan and test results. If the test results are negative, this counseling would include review of an individualized prevention plan. If they are positive, counseling would include review of services available for medical care and follow-up. It would also entail discussion of primary prevention for partners and others to avoid transmission and secondary prevention to reduce chances of increasing the viral load through reinfection.

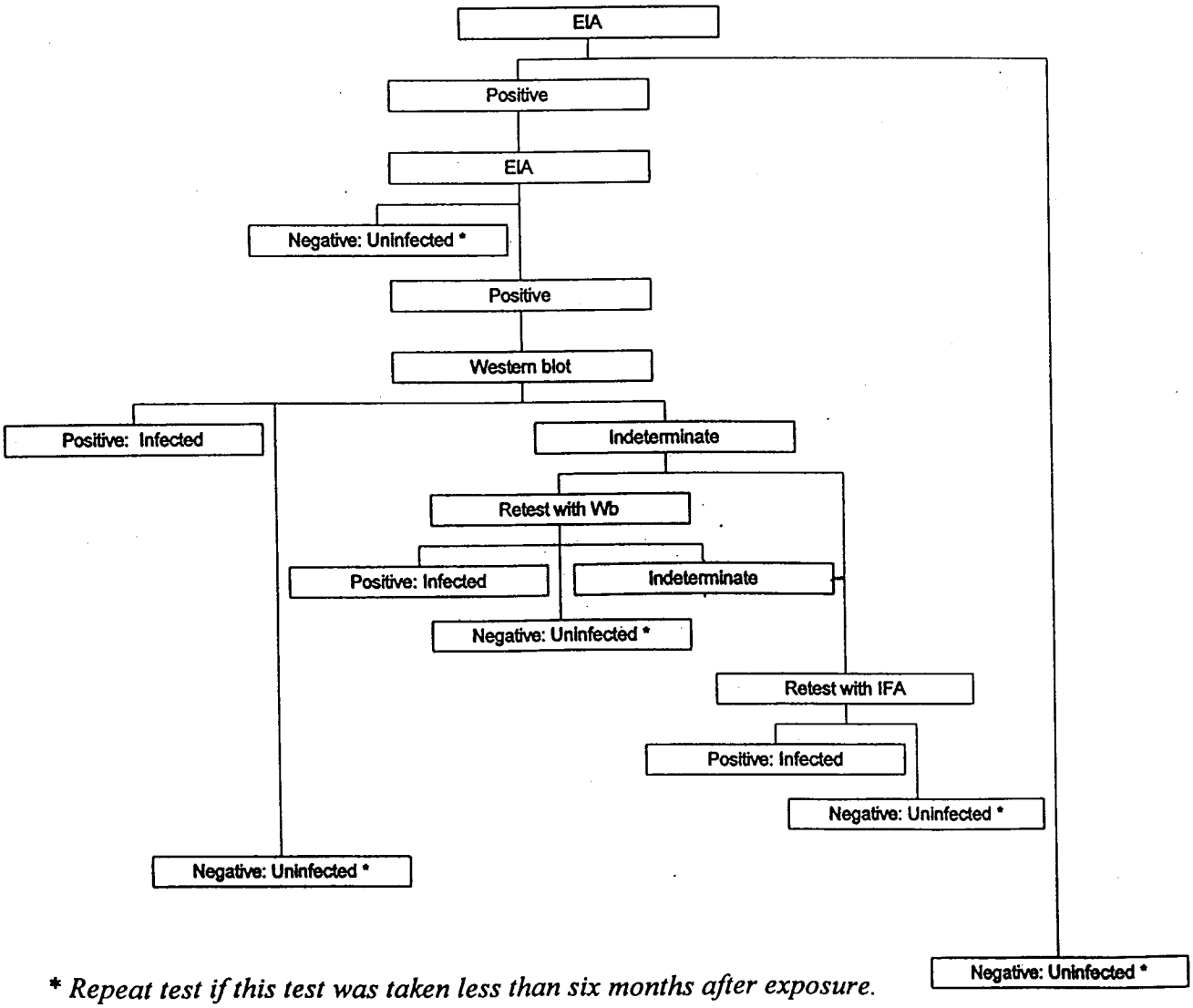
The Center for Disease Control and Prevention has published, "HIV Counseling, Testing, and Referral: Counselor and Provider Standards and Guidelines," to define the appropriate content of counseling sessions. Refer to Appendix A for details.

Interpretation of HIV Test Results

HIV infection is determined by first testing with the Enzyme Immunassay (EIA). Positive specimens are tested with a confirmatory test which may be either the WB or the Immunofluorescence Assay (IFA). Individuals who test negative on the EIA are considered to be uninfected. A person who is positive on the EIA **and** positive on either the WB or IFA is considered to be infected. Individuals positive on the EIA **and** negative on either the WB or IFA are considered to be uninfected.

It is important to determine whether the patient is being tested during the "window period" of infection when false negative tests occur. The "window period" is the period between infection and the point when tests can detect antibodies. This period ranges from two weeks to six months after infection, on average three months. Individuals who are positive on the EIA and indeterminate on confirmatory tests should be retested immediately to distinguish between recent seroconversion and a negative test (Figure 1). The IFA is less likely to yield an indeterminate test result than the WB. Women who remain indeterminate may have to be tested with additional tests, e.g., viral culture, polymerase chain reaction, or the p24 antigen test.

Figure 1. HIV Testing and Interpretation in Older Children and Adults



** Repeat test if this test was taken less than six months after exposure.*

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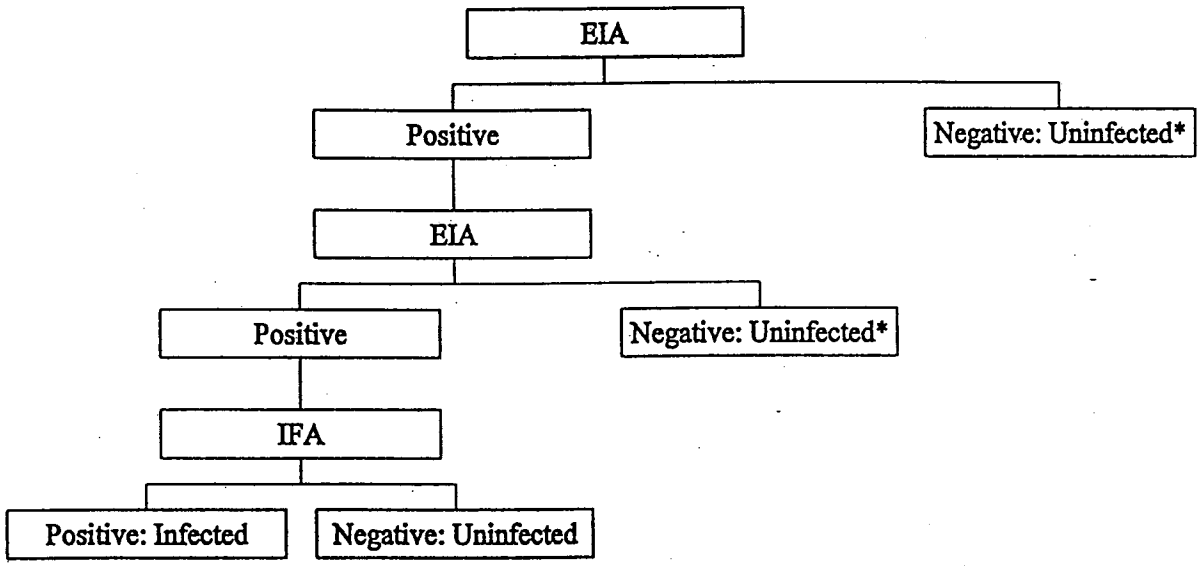
If a sample analyzed at a KDHE-supported counseling and testing site is positive on the EIA, then an IFA test is done (Figure 2). For more information on HIV testing considerations, refer to MMWR 1995; Vol 44/No. RR-7.

Antibody-based test results must be interpreted in the context of risk. Learning the date of last exposure in relation to the test date is important. HIV antibodies are not detectable by the current tests until two weeks to six months after exposure. It is recommended that individuals with negative tests results are retested three and six months after exposure if the test was done less than six months after exposure. People who are at the terminal stages of AIDS, because of the severe immunocompromise, may also have a false negative tests.

Figure 2. HIV Testing Protocols Used At Counseling and Testing Sites



** Repeat test if this test was taken less than six months after exposure.*

Options for HIV Counseling and Antibody Testing

KDHE-Supported Counseling and Testing:

A. Eligibility

Public funds for HIV counseling and antibody testing are limited. In order to deal with this reality, the KDHE Counseling, Testing, Referral and Partner Notification Program (CTRPN) targets its resources to reach populations at greatest risk. High risk populations are defined as those in which the incidence of HIV is higher than the general population and/or individuals are known to engage in behaviors likely to transmit the virus. These groups include men who have sex with men, injection drug users and their sex partners, and

Pregnancy alone is not a risk for infection. However, a pregnant woman's previous behaviors may have put her at high risk. Risk assessment is an essential activity conducted by all KDHE-supported counseling and testing sites.

Before being tested through a Kansas Department of Health and Environment (KDHE) site, individuals meet with a counselor to discuss possible risks for HIV infection. If the counselor determines that the client's risks do not fit into one of the high-risk categories mentioned above, then the client is referred to other sources for testing. Anyone who has engaged in one or more high-risk behaviors may be tested through a KDHE site.

B. Location

KDHE contracts with public HIV counseling and testing sites throughout the state.
For information on site locations, call (785)296-6174 or your local health department.

C. Payment

Charges are based on a sliding fee scale. No one is denied services based on an inability to pay.

Services Through Others:

Medicaid (HMO):

A. Eligibility - All Medicaid beneficiaries with current enrollment status, including pregnant women..

B. Location - Medicaid HMO providers.

C. Payment - HIV counseling is considered a part of comprehensive prenatal care. Reimbursement for testing is the responsibility of the HMO.

Medicaid (Health Connect/fee for service):

A. Eligibility - All Medicaid beneficiaries with current enrollment status, including pregnant women.

B. Location - Medicaid Health Connect providers.

C. Payment - HIV counseling is considered a part of comprehensive prenatal care. Medicaid will pay for HIV blood sample analysis performed **ONLY** by the Division of Health and Environmental Laboratories (DHEL). Any Health Connect provider may submit the specimen to DHEL for analysis. Medicaid beneficiaries under 21 years of age must have a current EPSDT (KAN Be Healthy) screen in order for the HIV sample analysis to be covered. Refer to the Medicaid Provider Manual for further details.

For information on Kansas Medicaid services, contact SRS Medical Services at (785)296-3981.

Privately Insured:

A. *Eligibility* - varies with each provider.

B. *Location* - providers may arrange with private laboratories for blood analysis relating to HIV antibody testing.

C. *Payment* - coverage of counseling and testing according to the consumer's health insurance plan and/or medical office/agency policy. The insurer should be contacted regarding payment for services.

Uninsured:

A. Eligibility - varies depending on service provider and/or risk factors

B. Location - charitable, private and public providers

C. Payment - payment for counseling and testing will depend on medical office/agency policy.

Services for HIV-Positive Patients

Kansas Department of Health and Environment:

Care:

The Kansas Department of Health and Environment receives limited federal funding for care services for HIV-infected individuals. Services include reimbursement to provider pharmacies for ZDV for any HIV-infected woman who is pregnant and whose physician has prescribed the medication for prophylaxis in the prevention of perinatal transmission. ZDV administered to infants is also covered on the drug reimbursement program, so long as the infant's family meets eligibility criteria for program enrollment.

For more information on KDHE's care services, call (785)296-8891.

Partner Counseling:

Post-test counseling for HIV-positive patients should include discussion about follow-up with sex and/or needle-sharing partners of the patient. All Kansans diagnosed are encouraged to utilize partner counseling through Medical Investigators. Medical Investigators are trained to locate and counsel partners about possible exposure to HIV. This is done without disclosing the name of the source patient; Medical Investigators are available to interview patients in the physician's office or at any arranged location.

For more information on partner counseling, contact the Kansas Department of Health and Environment AIDS Program at (785)296-5598.

Other Resources:

Medicaid:

The Medicaid program provides a wide variety of services for its beneficiaries. If a woman is HIV-infected, pregnant, and a current Medicaid beneficiary, she would be able to access comprehensive prenatal, intrapartum and postpartum care; medications; and medical care for the infant after delivery. Services may also include home health, durable medical equipment, laboratory testing, and all medically necessary services.

For more information on Kansas Medicaid services, contact SRS Medical Services at (785)296-3981.

Private Insurance:

Coverage may vary. The insurer should be contacted regarding payment for treatment and other services.

Uninsured:

Coverage for treatment will depend on provider/agency policy and/or availability of funding.

References

1. U.S. Public Health Service recommendations for human immunodeficiency virus counseling and voluntary testing for pregnant women. MMWR 1995; Vol. 44/ No. RR-7.

2. Public Health Service task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States. MMWR 1998; Vol. 47 / No. RR-2.

3. Connor EM, Sperling RS, *et al.* Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. N Engl J Med 1994:331: 1173-80.

4. Control of Communicable Diseases Manual. 16th edition: 4.2

HIV COUNSELING, TESTING, AND REFERRAL

Counselor and Provider Standards and Guidelines

Risk Assessment

Risk assessment—an integral component of HIV prevention counseling—is based on the premise that certain behaviors increase risk for infection with HIV. The counselor should engage the client in a discussion which enables the client to recognize and accept personal risk for HIV. Because the risk-assessment process serves as the basis for assisting the client in formulating a plan to reduce risk, it is an essential component of all pretest counseling.

When the counselor assesses a client's risk or reviews risk information previously recorded by the client or a clinician, the approach should be thorough and individualized for each client. The counselor should accept that the client's disclosures concerning risk behaviors correspond to his or her readiness to initiate behavior change. Each counselor should develop effective interactive methods to involve the client in identifying risk behaviors.

Standards

- Assure the client that test results and other information he or she provides will remain confidential.
- Determine the client's prevention and clinical needs by engaging him/her in a discussion that addresses: client's reason for visit and other relevant concerns; other personal circumstances; client's resources and support systems; behavioral and other sources of risk, demographic and epidemiologic factors that influence risk; client awareness of risk; readiness to change behavior; and receptiveness to available services and referrals.
- Listen for and address, as appropriate, information such as the following:
  - Number of sex partners (casual and steady) and sexual activities including vaginal, anal, and oral sex, both receptive and insertive activities;
  - Sex with a person known to be HIV-positive;
  - Sharing needles or having sex with persons who share needles;
  - History of STDs and having sex with persons who have STDs, especially genital lesions;
  - Assessment of current STD symptom status;
  - Sex in exchange for drugs, money, or other inducements;
  - Use of substances such as alcohol, cocaine, etc., in connection with sexual activity;
  - History of HIV antibody testing and results;
  - Condom use; and
  - Birth control—pregnancy prevention methods.
- Document acknowledged risk behavior, decisions about testing, and negotiated risk reduction plans in the client's record.

SPECIAL CONSIDERATIONS

- Risk assessment information may also be obtained by:
  - the clinician during the sexual/drug/medical history prior to or as a component of the counseling session;
  - utilizing a risk assessment tool completed by the client prior to the counseling session.

HIV-Prevention Counseling

Counseling provides a critical opportunity to assist the client in identifying his or her risk of acquiring or transmitting HIV. Counseling also provides an opportunity to negotiate and reinforce a plan to reduce or eliminate the risk. Counseling prior to HIV testing, prevention counseling (pretest counseling), should prepare the client to receive and manage his or her test result. Prevention counseling should also: 1) facilitate an accurate perception of HIV risk for those who are unaware, uninformed, misinformed, or in denial; 2) translate the client's risk perception into a risk reduction plan that may be enhanced by knowledge of HIV infection status; 3) help clients initiate and sustain behavior changes that reduce their risk of acquiring or transmitting HIV. Unless it is prohibited by state law or regulation, clients should be offered reasonable opportunities to receive HIV-antibody counseling and testing services anonymously. The availability of anonymous services may encourage some persons at risk to seek services who would otherwise be reluctant to do so.

Standards

- Assure the client that test results and other information he or she provides will remain confidential.
- Discuss anonymous testing options.
- Provide client-centered counseling to:
  - Establish and/or improve the client's understanding of his/her HIV risk;
  - Assess the client's readiness to adopt safer behaviors by identifying behavior changes the client has already implemented; and
  - Negotiate a realistic and incremental plan for reducing risk.
- Discuss clients history of HIV testing and results.
- Involve the client in an assessment to determine his or her behaviors which result in a risk of acquiring HIV infection.
- Tailor the counseling session to the behaviors, circumstances, and special needs of the client.
- Assist the client in recognizing those behaviors which put him or her at risk for HIV.
- Identify steps already taken by the client to reduce risk and provide positive reinforcement.
- Identify barriers/obstacles to the client's previous efforts to reduce risk.
- Determine one or two behavioral changes the client may be willing to make to reduce risk.

- Discuss the steps necessary to implement these changes.
- Address any difficulties the client anticipates in taking these steps.
- Respond to the client's concerns.
- Provide the client with necessary referrals and a written copy of the risk reduction plan (this plan should not include any personal identifiers). For clients who cannot read, a verbal summary should be provided.
- Assist the client to arrive at an appropriate decision concerning HIV testing.
- Obtain informed consent from the client prior to testing.
- Establish a plan with the client to receive test results.

Guidelines

- Document the risk assessment in the client's record for use during subsequent care.
- Document the risk reduction plan in the client's record.
- Ensure that the client understands the risks and benefits of knowing his or her HIV infection status.
- Discuss the client's expectations of test results.
- Discuss the client's plan to cope while waiting for test results.
- Explore with the client support systems that may be available.
- Ensure that the client understands what will happen during his or her visit to receive test results.
- Discuss the client's responsibility to disclose HIV infection status to sex/needle sharing partners.

SPECIAL CONSIDERATIONS

As part of the assessment, the counselor should ascertain the client's understanding of HIV transmission and the meaning of HIV antibody test results. When appropriate and relevant to the client, the counselor may:

- **Discuss what the virus is and how it is transmitted.**
  Assist the client to comprehend transmission of HIV and the delay between infection and development of a positive test.
- **Discuss what the test results mean and how they are used in medical management.**
  Negative Result - A negative test means that the person is either (1) not infected, or (2) so recently infected that the test could not detect the infection.
  Positive Result - A positive test means that the person is infected with HIV and can transmit it to others.
- **Discuss need for retest.**
  Clients engaging in continued high-risk behavior should be retested 6 months after the last possible exposure to any HIV risk. (See "Counseling and Repeat Testing" Section.)
- **Review risk reduction options with the client, for example:**
  - Abstain from sex and injecting street drugs; enroll in a drug treatment program.
  - Practice mutual monogamy between two HIV negative persons.
  - Use condoms to prevent STDs and HIV transmission.
  - Modify sexual practices to low or no risk behaviors.
  - Limit the number of sex partners.
  - Disinfect drug injecting equipment and avoid sharing paraphernalia.
- **Advise persons with behavioral risk for HIV not to donate blood and not to use the blood bank as a means of periodic HIV testing.**
- **Discuss related healthy behaviors, for example:**
  - Limit the use of alcohol and other drugs.
  - Obtain family planning assistance, when appropriate.
  - Obtain early diagnosis and treatment for STDs, when appropriate.
- **Explain authorized disclosures and antidiscrimination protection.**
- **Discuss bringing a support person of the client's choice, at the time of receiving test results.**

Notification of HIV Results and Prevention Counseling

Providing HIV antibody test results to a client involves interpretation that is based on the test result and the person's specific risk for HIV infection and dealing with the client's reaction to his/her test result. The client will most often focus on the result itself. Client-centered counseling is required to reassess behavioral risk that may influence the interpretation. When the client receives HIV test results, the primary public health purposes of counseling are (1) to reinforce perception of risk for those who are unaware or uninformed; (2) to help uninfected persons initiate and sustain behavior changes that reduce their risk of becoming infected; (3) to arrange access to necessary medical, prevention, and case management services for persons with a positive test result; (4) to assist those who may be infected to avoid infecting others and remain healthy; and (5) to support and/or assist infected clients to ensure the referral of as many sex or needle sharing partners as possible.

Knowledge of HIV status is an important piece of information a client can use in planning the scope of behavioral changes. Persons who abstain or have sexual relations with others who are known to be free of HIV infection and who do not use injecting drugs can essentially eliminate their risk of acquiring HIV. However, the consistent and correct use of condoms or the adoption of certain non-insertive sexual activities can greatly reduce the risk of acquiring or transmitting HIV. Although methods may be employed to reduce the risk of HIV from injecting drug use (such as the use of new needles), injecting drug use constitutes a health risk even in the absence of HIV and must be avoided.

The risk assessment and risk reduction plan developed during counseling prior to HIV testing provide a framework for strengthening efforts the client has already taken toward healthier behaviors and for recommending modifications based upon the HIV test result.

Standards

- Review available documentation including the risk assessment, prior to meeting with the client.
- Assure the client that test results and other information he or she provides will remain confidential.
- Provide HIV positive test results only by personal contact, assuring a confidential environment.
- Provide counseling at the time results are given to:
  - Assess the client's readiness to receive HIV test results;
  - Interpret the result for the client, based on his or her risk for HIV infection;
  - Ensure that the client understands what the result means and address immediate emotional concerns; and
  - Renegotiate or reinforce the existing plan for reducing risk considering the client's HIV status.
- Discuss with the client the need to appropriately disclose HIV status.
- Assess the client's need for subsequent counseling or medical services.
- Develop a plan to access necessary resources and appropriate referrals.
- For use during subsequent clinical care, document test results, risk reduction plan, and identified need for any resources and referrals in the client's chart.
- Ensure that confidentially tested HIV infected clients who do not return for results and counseling are provided appropriate follow-up. Document all follow-up. Exhaustive efforts should be made to ensure that confidentially tested HIV infected clients are offered their HIV test results and counseling.

Interpretation of HIV antibody test results depends upon the client's risk behaviors. Some recently infected clients may have negative antibody tests. Indeterminate results may represent a recent HIV infection or a biologic false positive. Eliciting specific information about recent risk behavior is essential to accurate interpretation and counseling.

The client will likely encounter circumstances where it is appropriate to reveal their HIV infection status (e.g., to health care or dental providers; past, present, or potential sex and needle sharing partners). It is important to discuss such situations with the client and assist in developing a plan and skills for appropriate disclosure of HIV infection status.

Guidelines

I. Negative HIV Test Result

- Ensure that the client understands what the test result means including:
  - Limitations of test (i.e., time lag between infection and development of antibodies); and
  - Need for periodic retesting if the client participates in risk behaviors.
- Identify any steps already taken by the client to reduce risk and provide positive reinforcement.
- Encourage the client to continue avoiding risk behaviors.
- Determine one or two behavioral changes the client may be willing to make to reduce risk and discuss steps to implement these changes.
- Assist the client in building skills to negotiate risk reduction activities with current or potential partners through discussion and role plays.
- Offer referral for further assistance in avoiding risk behaviors and maintaining low-risk behaviors.
- Discuss his/her need and ability to help partners realize they are also at risk for HIV infection.
- Reinforce the importance of discussing risk reduction measures with potential partners; identify any difficulties the client perceives.
- Advise client about importance of early STD detection and treatment to reduce HIV risk.
- Advise client to refrain from donating blood, plasma, and organs.
- Advise client on access to other prevention and treatment services (i.e., drug treatment, psychosocial support, etc.)

II. Positive HIV Test Result

Some HIV positive clients may be better prepared to receive positive test results than others. Counseling of patients with positive results must be directed to the client's specific circumstances and may require more than one session. Counselors should recognize that the emotional impact of learning about an HIV positive test result often prevents clients from absorbing other information during this encounter. Counselors may need to arrange additional sessions or provide appropriate referrals to meet the client's needs and accomplish the goals of counseling persons who are HIV positive.

- Allow time for the client's emotional response after learning his or her positive HIV result. A subsequent counseling session or follow-up telephone call may be required.
- Ensure that the client understands what the test result means.
- Assess the client's immediate needs for medical, preventive, and psychosocial support. (e.g., financial, personal, and other)
- Make the client aware of the need for additional medical evaluation and the availability of treatment.
- Establish a plan for continuing medical care and psychological support, including a subsequent prevention counseling session if necessary. As part of the plan, the counselor should:
  - Identify necessary referrals and assist the client with contacting them, and
  - Provide the client with written referral information.
- Reassess the client's risk for transmitting HIV infection.

- Help facilitate behavior change and/or reinforce behaviors that minimize or eliminate risk of transmission.
- Discuss with the client access and availability to ongoing prevention services including psychosocial and support services.
- Discuss with the client the responsibility to assure that sex and/or needle-sharing partners are counseled about their exposure to HIV and the need for them to seek medical evaluation.
- Assist the client in developing a plan which ensures that all partners are counseled about their exposure to HIV.
- Discuss how the client will notify other persons of his or her HIV status including future sex and needle-sharing partners, health care providers, and dental providers.
- Discuss with the client his or her specific plans for the next few days and ensure that the client has access to support systems during this time.
- Advise client to refrain from donating blood, plasma, and organs.

The current testing strategy of two EIA determinations followed by a supplemental test for confirmation, such as the Western blot, makes false positive test results extremely unlikely; however, the possibility of a mislabeled sample or laboratory error must be considered, and for a client with no identifiable risk for HIV infection, a repeat test may be appropriate.

SPECIAL CONSIDERATIONS

- Clients whose results are HIV positive may have specific medical questions. Considering the complexity of medical questions, responses should be left to clinicians to whom the client is referred, or to counselors or case managers with specific expertise in this area.
- Some clients may be at very high risk of transmitting the virus to others. Sites are encouraged to provide, either on-site or through referral, additional prevention counseling (individual, couple, group, or peer), as appropriate to the needs of these clients.
- Counselors should appreciate the complexity of reproductive decision-making for HIV-infected women and must be familiar with the most recent Public Health Service recommendations on antiretroviral therapy to prevent vertical transmission. (1)

III. Indeterminate Test Result

- Explain that the test result is inconclusive and may represent either:
  - a biologic false positive test, or
  - a truly positive test from a recent infection in which antibodies have not yet fully developed.
- Schedule a repeat test approximately 6 weeks after the date of this inconclusive test.
- Emphasize that the client must take the same risk reduction precautions as persons testing HIV positive until the indeterminate finding is resolved.
- Assess the client's concerns and anxieties during the waiting period. If necessary,
  - arrange psychological referral to assist the client with coping while resolving the indeterminate test result,
  - provide a hotline telephone number(s) as a referral option, and
  - provide a subsequent counseling session or follow-up telephone call.

Counseling and Repeat Testing

Situations where clients need repeat HIV counseling or request repeat HIV testing challenge and pose difficult issues for counselors. These situations include previously counseled persons who continue to place themselves or others at risk for infection, persons with indeterminate test results, seronegative persons with no risk who continue to request testing, and persons doubting or disbelieving their seropositive test results. Repeat testing is not advised as a substitute for initiating and maintaining safer behaviors.

Standards

- Assess the reasons the client requests repeat testing or continues risk behaviors.
- Emphasize that repeated testing for HIV will not prevent infection if the client continues to engage in risk behaviors.
- Arrange the specific services to meet the client's needs.
- Document all counseling activities, negotiated plans, and referrals in the client's record.

Guidelines

I. **Persons with Continued Risk — Previous HIV Test Negative**

The counselor should:

- Review previous risk assessment and risk reduction plan with client.
- Proceed with HIV counseling as outlined in the Section, **"HIV Prevention Counseling."**
- Provide alternative counseling options (e.g. referral to community based group or individual counseling) to the client to further help him or her understand his or her recidivist risk behavior(s) and modify the behaviors accordingly.
- Acknowledge incremental behavior changes, reinforce those which have reduced risk, and document in the client's chart.
- Identify obstacles which the client encountered in adopting safe behaviors.
- Explain potentially negative impact of HIV reinfection or exposure to other STDs.

II. Persons with Continued Risk—Previous HIV Test Positive

- Explain the continued risk of infecting sex and needle sharing partners.
- Negotiate a plan with the client to prevent HIV transmission.
- Identify resources and alternative counseling options to ensure that the client implements this plan and to reinforce the importance of practicing safer behaviors to protect himself or herself and others.
- Reinforce the importance of informing partners and making risk-reduction decisions with partners.
- Ensure that the client understands the adverse impact of STDs and drug use upon immune function.

III. Persons with Indeterminate Test Results

The counselor should:

- Arrange a repeat test approximately 6 weeks from the date of this current test;
- Assess the client's concerns and level of anxiety during the waiting period. If necessary, arrange psychological referral to assist the client in coping;
- Consider persons to be negative for antibodies to HIV if their Western Blot test results continue to be consistently indeterminate for at least 6 months in the absence of any known risk behaviors, clinical symptoms, or other findings (2);
- Encourage the client to follow guidelines outlined in the "Notification of HIV Results and Prevention Counseling Section."

IV. Persons with No Risk—Negative Test Results

The counselor should:

- Counsel the client on modes of HIV transmission and behaviors that place persons at risk for HIV;
- Counsel the client on unwarranted fears;
- Arrange referral for additional counseling for clients who continue to exhibit unfounded anxiety about HIV.

V. Persons Who Doubt Previous Seropositive Test Results

The counselor should:

- Assess why the client doubts the accuracy of the test results;
- Explain the process of multiple tests to confirm a positive result;
- Assist the client in recognizing behaviors that lead to HIV infection.
  - For clients with no acknowledged risk for HIV, repeat the test.
  - For clients with behavioral risk for HIV, arrange for medical referral and repeat test, if necessary.

REFERENCES

1. CDC. Zidovudine for the Prevention of HIV Transmission from Mother to Infant. *MMWR*, 1994;43(16):285-287.
2. CDC. Interpretation and use of the Western Blot Assay for Serodiagnosis of Human Immunodeficiency Virus Type 1 Infections. *MMWR*, 1989;38(S-7):1-7.

Referral Process

A thorough client assessment often indicates a need for services that cannot be provided by the counselor. The counselor has two opportunities to make referrals: (1) the HIV prevention counseling session, and (2) the test notification/prevention counseling session.

Standards

- Provide appropriate referral resources for:
  - Any client who may be in need of support to maintain safer behaviors,
  - HIV negative clients who continue to engage in risk behavior,
  - HIV negative clients who continue to test but are without risk,
  - HIV positive clients who continue to engage in risk behaviors, and
  - HIV positive clients with additional medical, social, or psychological needs.
- Provide the client with a written list of referrals including telephone numbers, addresses, hours of operation, and services provided.
- Document referrals in the client's record. Referrals made during the initial HIV prevention counseling session should be followed-up during the test notification/prevention counseling session.

Guidelines

The counselor should:

- Offer referral to case management provider, if one is available;
- Seek feedback from the client about preferences for referrals, the accessibility of the referral, and the client's intention to follow through with the referral;
- Provide the client with relevant details about referral sites, e.g., the name of a specific contact person.

SPECIAL NOTE

Any HIV positive or negative client who continues to engage in risk behaviors should know where and how to access STD examination and treatment services.

Source: U.S. Public Health Service